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Good afternoon Senator Crisco, Representative Megna and members of the Insurance and Real Estate Committee. We are here to testify in support of SB 807 AN ACT CONCERNING FAIRNESS AND EFFICIENCY IN HEALTH INSURANCE CONTRACTING and SB 808 AN ACT CONCERNING THE ESTABLISHMENT OF A DISPUTE RESOLUTION PROCESS FOR SURPRISE BILLS AND BILLS FOR EMERGENCY SERVICES.

SB 807 would promote the use of low-cost, high-quality health care providers and mitigate the anticompetitive effects of hospital consolidations. It would require development of a tiered network pilot program that, while not limiting the number of providers or restricting the choice of doctors, would provide financial incentives to patients for choosing lower cost/higher quality providers. The bill would require that all insurers offer at least one tiered network plan. Under this bill, variations in member cost sharing between provider tiers must be reasonable and the plans must provide adequate access to covered services at all levels. This legislation supports patient empowerment and consumer driven healthcare.

In order to mitigate the anti-competitive effect of hospital consolidation, SB 807 would prohibit hospitals and health systems from requiring that payers contract with all provider locations or facilities within their system or for all services offered; the bill would also require

that hospitals located in the same market negotiate separately even if they are commonly owned. In addition, this bill would require site neutral payment for MedPAC group one and two procedures. These are procedures that MedPAC has determined can be done as safely in a physician's office as in a hospital; this requirement is consistent with our legislation regarding facility fees. In addition, the bill would prohibit a hospital from billing for outpatient services under its tax identification number.

In order to facilitate price transparency, the legislation would prohibit contract terms that prohibit or limit the disclosure of price, cost or claims information. Finally, this legislation requires that the Commissioners of Insurance and Public Health develop standardized forms for billing, benefit summaries, out of pocket expenses, and prior authorization. We would like to add a requirement that these forms be easily understood by the average patient which would be another step to allow patients to make more educated choices.

The language currently drafted in SB 808 is a placeholder that creates a dispute resolution process; while a dispute resolution process is a necessary part of this legislation, it is not alone sufficient. The issue of surprise medical billing was brought to the forefront in part by an Elsabeth Rosenthal article in the New York Times last September: *After Surgery, Surprise $117,000 Medical Bill From Doctor He Didn't Know.* Not only did one patient in the article get a bill for $117,000 from a doctor he had never seen, the article also illustrated the difference between the in-network reimbursement rates and actual bills. For example, the average in-network rate for gallbladder removal is $1842 while the bill for this surgery is $44,000. For a spinal fusion the rates are $5,893 versus $115,625. It is no wonder medical bills are a leading cause of bankruptcy.

This bill, in its final form, will protect patients with emergency medical needs who generally are not in a position to choose a provider and require in non-emergency situations that providers and insurers provide patients with the information they need regarding network status to make educated choices when selecting providers.

Under this legislation, a patient receiving emergency medical services would not be required to pay more than the amount the patient would normally pay for in-network care; the bill would also prohibit balance billing by the out of network providers performing emergency care. The Affordable Care Act (ACA) provides certain protections for patients receiving emergency care, but the ACA does allow limited balance billing. Our bill would prohibit balance billing.

For non-emergency care, if there are in-network options available, the bill would require health care providers to disclose to a patient, at the time the patient makes an appointment and prior to the provider performing any medical service or treatment, the provider's network status within the patient's health care plan. It would require that a patient be responsible for only the in-network copay, coinsurance and deductible for the appointment, medical service or treatment if the provider fails to provide the required disclosure. The legislation would also require insurers to inform patients, when authorization is sought for a particular service, the network status of the health care provider providing the service, the amount the insurer will reimburse the provider for the service and how this amount compares to the usual, customary and reasonable charges for such service. In addition, the bill would require the departments of Public Health and

Insurance establish a review process to resolve fee disputes between health care providers and insurer.

SB 808 should also codify the appeal process that patients can use when they have received care from an out of network provider only because there are no appropriate in-network providers available. These patients should be billed the in-network copay, coinsurance, and deductible for a medical service or treatment. There should also be a notification requirement that if there are no in-network providers available, patients can appeal and receive coverage for services provided by out-of-network providers.

Thank you for hearing these important bills that taken together create much needed patient protections